

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-012459

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED APR 4 1963

VS 300
Rev. 4/59

DATE AMENDED

INSTEAD OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Marion		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Shelby	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Hannibal		Length of stay in 1b 6 Days	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Elizabeth Hosp.		d. STREET ADDRESS (If outside, give location) Shelbina	
3. NAME OF DECEASED (Type or print) First Lillie Middle May Last Schwietter		4. DATE OF DEATH Month March Day 21 Year 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Aug. 12, 1888 - 75
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. FATHER'S NAME Wesley Jerrell		13b. MOTHER'S MAIDEN NAME Mary Jane Philliber	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT J. L. Forman, Laramie, Wyoming	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pyelonephritis DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a). Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 1 year	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____	
21. I attended the deceased from 3-16 to 3-21 and last saw her alive on 3-21-63 Death occurred at 3 A m on the date stated above, and to the best of my knowledge, from the causes stated.		22b. ADDRESS 701 grand Hannibal, Mo.	
22a. SIGNATURE Dr. R. M. D.		22c. DATE SIGNED 3-25-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Mar. 24, 1963	
23c. NAME OF CEMETERY OR CREMATORY Shelbina Cemetery		23d. LOCATION (City, town, or county) Shelbina, Missouri	
24. FUNERAL DIRECTOR Hayes Funeral Home, Shelbina, Mo.		25. DATE RECD. BY LOCAL REG. March 28, 1963	
26. REGISTRAR'S SIGNATURE Dr. E. M. Lucke by Lillian M. Forman			

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Paul E. Hays

Licensed Embalmer No. 4461

P. O. Address Shelbina, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

Permit received 3/28/63